## ATTENDING DENTIST'S STATEMENT JNITED CONCORDIA Dentist's pre-treatment estimate Claims Processing P.O. Box 69411 Dentist's statement of actual services Harrisburg, PA 17106-9411 Relationship to sponsor self spouse child Patient birthdate mo day 5. If full time student school other year city Sponsor's name First 11. Branch of service middle last 12. Group name 7. Sponsor's social security no. TRICARE Dental Program E 8. Patient mailing address Dental plan name 13. Is patient covered by another dental plan? yes no City, State, Zip Insured name and soc. sec. no. Group no S ECT Name and address of carrier 9. Telephone number I have reviewed the following treatment plan. I authorize release of any 14. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to 0 information relating to this claim. the dentist listed below. N Signature (patient or parent if minor) Date Date Signature (insured person) 15. Dentist name 15a. Provider no If yes, enter brief description and dates Is treatment result D of occupational illness or injury? 16. Mailing address -- street address 24. Is treatment result of auto accident? 25. Other accident? S City, State, Zip 26. If prosthesis, is 27. Date of prior placement (If no, reason for replacement) this initial placement? SECT 17. Dentist soc. sec. or T.I.N. 18. Dentist license no. 19. Dentist phone no. 28. Is treatment for Appliance insertion date Total length of treatment orthodontics? First visit date current series 21 Place of treatment ice Hosp. ECF Other 29. Transfer patient? If no, starting date of treatment 22. Radiographs and/ No Yes How If yes, reband date Many? or documentation 0 7 Was patient rebanded? enclosed? 30. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown. Identify missing teeth DATE SERVICE TOOTH with "X" DESCRIPTION OF SERVICES AMOUNT PROCEDURE PERFORMED NO. OR SURFACE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) CHARGED PAID CODE LETTER MO. | DAY | YR 31. Remarks for unusual services 32. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act under state and/or AMOUNT PAID 33. TOTAL FEE federal law and may also be subject to civil penalties. I hereby certify that the procedures as indicated by date have been completed. CHARGED 34. PAYMENT OR COPAY OF

OTHER PLAN

Date

Signature (Dentist)

## Completing the TDP Claim Form

Most of the TDP Claim form is self-explanatory; however, there are certain fields to which special attention should be paid.

- <u>Upper left corner</u> (Attending Dentist's Statement): Check the appropriate box to indicate if your claim is for predetermination (estimate of services to be performed) or for services actually received.
- Box 2. Relationship to Sponsor. For example, self, spouse, or child.
- Box 7. Sponsor's Social Security Number (SSN). The sponsor's nine-digit SSN <u>must</u> appear on every claim form.
- Box 8. <u>Patient's Mailing Address</u>. Be sure to provide the current and complete mailing address
  to include APO/FPO and/or street, city, country, and postal mailing code.
- Box 10. Release of information.
- Box 13. Is the patient covered by another dental insurance plan. Check 'No' if the family member has no other dental insurance. If the family member has additional dental insurance, please check 'Yes' and include the plan name, insured name and social security number, group number, and address of the other carrier.
- Box 14. <u>Assignment of Benefits</u>. Sign if the family member, parent, or guardian wants to assign
  payment of benefits to the dentist; if signed, United Concordia will send payment to the dentist
  directly.
- Box 15. <u>Dentist name and provider number</u>. The provider number represents the provider number assigned by United Concordia.
- Box 16. Dentist address. Include street, city, country, and postal mailing code.
- Box 30. <u>Examination and Treatment Plan</u>. Provide a detailed description of the services performed including applicable tooth numbers, dates of service, and fee charged.

## **General Instructions**

- Submit a separate claim form for each member who receives treatment.
- All claim forms should be submitted to United Concordia as soon as possible after the service date, preferably within 60 days of the date of service. Claims postmarked more than 12 months after the date of service will be denied.
- The member must sign the appropriate sections of the claim form. If the family member is under 18 years of age, the parent or guardian must sign the form.
- The dentist must sign the appropriate sections of the claim form.